

Case Number:	CM13-0040638		
Date Assigned:	12/20/2013	Date of Injury:	09/11/1999
Decision Date:	02/05/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	10/10/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, is Fellowship trained in Spine Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 60-year-old female who reported an injury on 10/23/2001. The patient is currently diagnosed with left carpal tunnel syndrome, multi-level degenerative disc disease and disc protrusion with facet spondylosis, severe and posttraumatic patellofemoral arthritis of bilateral knees, osteochondral defect of the dome of the left talus, lumbosacral spondylosis, spinal stenosis, arthrodesis, thoracic and lumbosacral neuritis or radiculitis, osteoarthritis, medial meniscal tear, osteochondritis dissecans, sprain and strain of the ankle and traumatic arthropathy of the ankle and foot. The patient was seen by [REDACTED] on 12/30/2013. The physical examination revealed minimally antalgic gait, diminished range of motion, moderate tenderness over the surgical scar, moderate to severe tenderness in the paraspinal muscles, moderate to severe tenderness at the sacroiliac joints, absent deep tendon reflexes at bilateral knees and ankles, 5/5 motor strength without neurological deficit, and negative straight leg raising. Treatment recommendations included exploration of the lumbar fusion with removal of the retained pedicle screw as well as postoperative physical therapy and continuation of current medication.

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IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**LUMBAR FUSION WITH REMOVAL OF RETAINED PEDICLE SCREWS
HARDWARE AND INPATIENT LENGTH OF STAY: Upheld**

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion (spinal), Hardware implant removal (fixation)

Decision rationale: California MTUS/ACOEM Practice Guidelines state surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation due to radiating leg pain for more than 1 month, extreme progression of lower extremity symptoms, clear clinical and imaging study of a lesion that has been shown to benefit from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. Patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for a fusion. As per the clinical notes submitted, the patient does not exhibit neurological deficits on physical examination. There is no evidence of documented instability on flexion and extension view radiographs. Official Disability Guidelines state hardware implantation removal is not recommended except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. There is no evidence upon imaging study of hardware failure. Based on the clinical information received, the patient does not currently meet criteria for the requested surgical procedure. As such, the request for a lumbar fusion with removal of retained pedicle screws hardware and inpatient length of stay is noncertified.

POST-OP PHYSICAL THERAPY 2X6 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: California MTUS Guidelines state the initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the post surgical physical medicine treatment recommendations. Postoperative treatment following a spinal fusion includes 34 visits over 16 weeks. As the patient's surgical procedure has not been authorized, the current request for postoperative physical therapy is noncertified.

NORCO 7.5/325MG, SKELAXIN 800MG, AMBIEN 10MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 AND 74-82. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. California MTUS Guidelines further state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations in patients with chronic low back pain. However, they show no benefit beyond NSAIDS and pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of medications in this class may lead to dependence. Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. As per the clinical notes submitted, the patient has continuously utilized Norco, Skelaxin and Ambien. Despite the ongoing use, the patient continues to report increasing lower back pain with activity limitation. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. There is no evidence of palpable muscle spasm or muscle tension upon physical examination that may warrant the need for muscle relaxant. There is also no evidence of a failure to respond to first line treatment prior to the initiation of a second line muscle relaxant. Furthermore, there is no evidence of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product for insomnia. Based on the clinical information received, the request is noncertified.